QUARTERLY PREMIUM SURCHARGE PAYMENT FORM

Insurer Name_____
Address_____
City_____ **State**_____ **Zip Code**_____

Insurer NCCI Number_____

Date of Report	Quarter Ending Date	Dollar Amount Submitted

_____
CERTIFYING OFFICIAL (Type Name)

_____ _____
CERTIFYING OFFICIAL (Signature) **DATE**

_____
TITLE

_____
TELEPHONE NUMBER

Mail Form and Check to:
D.C. Department of Employment Services
Office of the Chief Financial Officer
64 New York Avenue, N.E., Suite 3093
Washington, D.C. 20002
(Telephone: 202-671-1400)

Submit a Copy of the Form to:
D.C. Department of Employment Services
Office of Workers' Compensation
Post Office Box 56098, Insurance Unit
Washington, D.C. 20011
(FAX: 202-671-1929)

(1) Checks are payable to the *D.C. Treasurer*.
(2) This form may be reproduced or downloaded from the DOES website. The website address **is www.does.dc.gov .**